The Commonwealth of Massachusetts
Department of Public Health
Bureau of Health Professions Licensure

Board of Registration in Nursing
250 Washington Street, 3rd fl., Boston, Massachusetts 02108

Substance Abuse Rehabilitation Program

Suboxone Provider Report

To the Physician prescribing Suboxone to the Substance Abuse Rehabilitation Program (SARP) Participant: *Please complete this form **within ten (10) days of providing services to the SARP Participant**. If you have any questions, please call the SARP Admin. Asst. at 617-973-0904.*

Name of SARP Participant (please print): _____

Date Suboxone Treatment began: _____

Toxicology screening dates and results: _____

Follow-up appointment scheduled for: _____

Prescription Information

DATE OF PRESCRIPTION	NAME OF MEDICATION	QUANTITY & DOSAGE PRESCRIBED, NUMBER OF REFILLS	RATIONALE FOR MEDICATION

_____ _____
Suboxone Provider's Name (please print) Provider's Signature / Report Date

_____
Provider's Address and Office Telephone Numbers

_____ _____
Provider's DATA 2000 Waiver Number Date